MDR Tracking Number: M5-04-3155-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on May 20, 2004.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that CPT Codes 97032, 97010, 97012, 97110 and 97139 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On July 15, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 19 days of the requestor's receipt of the Notice.

On July 13, 2004 the requestor submitted an updated table including dates of service that were not included in the original submission. Dates of service 03/17/04 through 03/26/04 were not included in the original request for dispute resolution; therefore, these dates will not be reviewed.

- CPT Code 97265 for dates of service 05/19/03 through 07/02/03. Neither party submitted EOBs. The requestor did not submit convincing evidence of the carrier's receipt of the provider's request for reconsideration in accordance with Rule 133.307(e)(2)(B). Reimbursement is not recommended.

This Decision is hereby issued this 17th day of November 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf
Enclosure: IRO Decision

MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-04-3155-01
Name of Patient:	
Name of URA/Payer:	Tri-State Physical Therapy
Name of Provider: (ER, Hospital, or Other Facility)	Tri-State Physical Therapy
Name of Physician: (Treating or Requesting)	Dan Turner, PT

October 7, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Rosalinda Lopez, Texas Workers Compensation Commission

CLINICAL HISTORY
Available information submitted for review suggests that this patient reports experiencing neck and back injury resulting from a fall at work ___. The patient was apparently examined initially in El Paso, Texas (where the injury occurred) and received a course of physical therapy treatment, but no specific reports of this available for review. The patient then moved to Shreveport, La. where he began seeing a Dr. Gleason, but no reports of Dr. Gleason's evaluation are provided for review. There do appear to be orders from Dr. Gleason dating from 04/07/03 recommending physical therapy at 3x per week for 3 weeks for a diagnosis of neck strain and post operative lumbar fusion re-injury. PT evaluation of 04/09/03 suggests significant pre-existing history of multiple back and neck surgeries dating back to 1998 while the patient was living in Wichita, Ks. Physical therapist recommends continuing PT modalities and exercises at 3x per week for 4 weeks. No review of previous physical therapy, treatment records or diagnostic studies appears to be performed. The patient appears to undergo approximately 33 physical therapy sessions from 04/09/03 to 07/02/03. PT report of 04/09/03 indicates a treatment plan consisting of soft tissue mobilization, joint mobilization and active exercise only. However, PT billing suggests that the patient receives mostly passive modalities including hot packs, massage, electric stimulation and mechanical traction. This includes unlisted procedures that appear to be for TENS unit, set-up and Jeltrodes (re-usable electrodes).

REQUESTED SERVICE(S)
Determine medical necessity for therapeutic modalities including electric stimulation (97032), hot/cold packs (97010), therapeutic exercise (97110), mechanical traction (97012), and unlisted therapeutic procedure (97139) for period in dispute 05/19/03 through 07/02/03.

DECISION
Denied. Medical necessity for these ongoing treatments and services (05/19/03 through 07/02/03) **are not supported** by available documentation.

RATIONALE/BASIS FOR DECISION

There appears to be some reasonable medical necessity for conservative care, including physical therapy, for these conditions for a period not exceeding *6-8 weeks duration post-injury* (sprain/strain superimposed on pre-existing post-operative conditions). PT treatment plan does not disclose nature and medical necessity for passive modality applications and some active procedures. Ongoing therapeutic modalities of this nature suggest little potential for further restoration of function or resolution of symptoms, with little or no curative potential. With available information suggesting significant pre-existing conditions and physical therapy already performed for superimposed conditions, it would appear that ongoing physical therapy modalities and treatment beyond 04/17/03 **would not be medically necessary** for compensable injury of ___. A review of previous therapy performed, diagnostic findings from treating doctors and specific complicating factors would be necessary in order to support ongoing care of this nature.

1. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.
2. Hurwitz EL, et al. *The effectiveness of physical modalities among patients with low back pain*: Findings from the UCLA Low Back Pain Study. J Manipulative Physiol Ther 2002; 25(1):10-20.
3. Bigos S., et. al., AHCPR, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.
4. Harris GR, Susman JL: "Managing musculoskeletal complaints with rehabilitation therapy" Journal of Family Practice, Dec, 2002.
5. Guidelines for Medically-based Outpatient Physical Therapy and Occupational Therapy for Post-Surgical Cervical Spine; HCFA, Pub 09, Rehabilitation Manual, HCFA., Pub 10, Outpatient Manual, Rehabilitation.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.